Statistical Bulletin

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Longevity of Industrial Population at New High

IN 1950 the expectation of life at birth for the Industrial policyholders of the Metropolitan Life Insurance Company reached an all-time high of 68.3 years—an increase of fully half a year over the figure for 1949. (See Table 1 on the next page.) The gain has amounted to 5⅓ years since 1940 and to 21⅔ years since 1911-1912, when the expectation of life at birth in the wage-earning population was 46.6 years. According to current mortality conditions, that many years of life still lie ahead for the average person who has already attained age 25. Thus the average length of life among the rank and file of the American people continues its long-term rise, with good prospects for further gains.

The increases in expectation of life have generally been largest at the younger ages and diminish progressively with advance in age. The experience of the past decade illustrates the point. At age 5, for example, the rise in expectation of life among these insured amounted to 4 years from 1940 to 1950, compared with 3.6 years at age 20 and 2.7 years at age 40. Even at age 65 there was a fairly substantial rise—namely, 1.4 years. This addition to the expectation of life at the threshold of old age is appreciable in relation to the average lifetime remaining—namely, 13.3 years in 1950. The outlook for an increased number of years beyond the usual age for retirement obviously has important social and economic implications.

Each color and sex group in this insurance experience has shared in the improvement in longevity in the past decade, but not in equal measure. Among both the white and the colored, females have a more favorable record than males. Among white persons at age 20, for example, the increase in average remaining lifetime between 1940 and 1950 was 3.7 years for females and 2.8 years for males. For the colored, among whom the corresponding gains were even greater, the increases were 5.4 years for females and 5.0 years for males. This greater gain for the colored than for the white has narrowed somewhat the disparity between the two groups. Neverthless, the whites still have a marked advantage over the colored in expectation of life.

TABLE 1—EXPECTATION OF LIFE AT BIRTH. PREMIUM-PAYING BUSINESS*
INDUSTRIAL DEPARTMENT, 1879-1889 TO 1950
METROPOLITAN LIFE INSURANCE COMPANY

CALENDAR YEAR	EXPECTATION IN YEARS	CALENDAR YEAR	EXPECTATION IN YEARS	CALENDAR YEAR	EXPECTATION IN YEARS
1950†	68.27	1939	62.50	1928	55.88
1949	67.72	1938	61.94	1927	56.42
1948	67.16	1937	60.71	1926	55.02
1947	66.50	1936	60.31	1925	55.51
1946†	65.57	1935	60.25	1924	55.62
1945†	64.95	1934	59.45	1923	54.55
1944†	64.40	1933	59.19	1922	55.04
1943†	63.86	1932	58.80	1921	55.08
1942†	64.26	1931	57.90	1919-1920	51.14
1941	63.42	1930	57.36	1911-1912	46.63
1940	62.93	1929	55.78	1879-1889	34.00

Gain, 1950 since 1911-1912, 21.64 years; since 1879-1889, 34.27 years.

*The figures for 1948 to 1950 relate to the total Industrial Department—Weekly and Monthly premium-paying business combined; prior to 1948 the figures pertain to the Weekly business alone. The expectation of life at birth for the total is about two fifths of a year greater than that for the Weekly premium-paying business.

†The figures for 1942-1946 and 1950 exclude deaths from enemy action.

TABLE 2—EXPECTATION OF LIFE AND MORTALITY RATE* PER 1,000 AT SPECIFIED AGE, BY COLOR AND SEX. TOTAL PREMIUM-PAYING BUSINESS, INDUSTRIAL DEPARTMENT, 1950
METROPOLITAN LIFE INSURANCE COMPANY

AGE	EXPECTATION OF LIFE					MORTALITY RATE PER 1,000				
	Total Persons	WHITE		COLORED		Total Persons	WHITE		COLORED	
		Males	Females	Males	Females		Males	Females	Males	Females
5	65.70	63.09	68.35	60.50	62.93	.69	.83	.61	.94	.70
10	60.86	58.27	63.50	55.69	58.10	.41	.49	.30	.45	.55
15	56.00	53.44	58.60	50.87	53.30	.68	.85	.41	1.26	1.05
20	51.22	48.70	53.74	46.27	48.65	1.03	1.24	.61	2.14	1.90
25	46.50	44.00	48.91	41.79	44.14	1.22	1.44	.79	2.56	2.20
30	41.79	39.33	44.12	37.34	39.62	1.53	1.75	1.07	3.38	2.64
35	37.13	34.69	39.38	33.02	35.19	2.20	2.46	1.58	4.53	3.78
40	32.60	30.19	34.73	28.81	30.91	3.56	4.32	2.49	6.36	5.47
45	28.26	25.95	30.21	24.83	26.84	5.64	7.20	3.86	9.61	7.99
50	24.13	21.99	25.85	21.10	22.98	8.37	11.41	5.71	13.38	11.10
55	20.22	18.37	21.65	17.59	19.32	12.47	17.45	8.77	19.00	15.49
60	16.58	15.10	17.70	14.38	15.94	19.08	25.93	14.01	28.26	23.29
65	13.29	12.19	14.06	11.57	12.91	29.29	38.11	23.05	42.23	33.35

*Exclusive of deaths from enemy action.

The longevity figures for 1950 are based upon the mortality rates shown in the right-hand panel of Table 2. Here is further evidence of the remarkable progress which has been made in reducing the toll of premature death. Rates under one per 1,000 are found among white males at ages 3 to 16 years and among white females in the age range 3 to 28 years. The picture for the colored is not as favorable. Death rates under one per 1,000 are found only from ages 5 to 13 years for colored males and from 4 to 14 years for colored females. The substantial room for improvement in mortality among the colored is clear from a comparison of their rates with those of white persons. From age 10 to almost age 50, colored females have mortality rates averaging twice those for white females. Indeed, at age 20 the ratio is more than 3 to 1.

The expectation of life has been increasing more rapidly among wage-earners and their families than in the general population of the United States. In 1911-1912, shortly after the Company launched its health and welfare program for policyholders, the industrial population was at a disadvantage of 6½ years in average length of life compared with the general population. Over the past four decades the difference has been gradually diminishing, until now the average length of life in the industrial population is the same as in the population as a whole. These facts are of particular interest at this time when so much attention is being focused on raising the level of industrial production in our country.

Spurt in World Population Growth

THE increase in world population has been accelerated in the postwar period through a resurgence of the birth rate and a decline in mortality in large areas of the globe. The gains, however, have not been uniform in all parts of the world, as may be seen from the table on page 4, which shows the crude rate of natural increase—the excess of births over deaths per 1,000 population—for various countries since 1920.

Population growth has been exceptionally rapid in the United States since the close of World War II. The annual excess of births over deaths has averaged better than 15 per 1,000—that is, more than 1.5 percent a year. This is somewhat above the level immediately following World War I and about twice the rate during the depression decade of the 1930's. In the past five years our population has grown by more than 11,000,000 through natural increase alone.

A trend fairly similar to that for the United States is found in both Canada and New Zealand. However, in several other English-speaking countries—England and Wales, Australia, and Scotland—the recent natural increase has fallen short of the level attained following World War I. This has also been the case for a number of countries on the Euro-

EXCESS OF BIRTHS OVER DEATHS PER 1,000 POPULATION, SELECTED COUNTRIES 1920 TO 1950

COUNTRY	1920-1924	1925-1929	1930-1934	1935-1939	1940-1944	1945	1946	1947	1948	1949	1950†
AMERICA											
United States	**14.8**	**11.4**	**8.7**	**7.8**	**10.7**	**10.1**	**14.5**	**16.9**	**15.5**	**15.4**	**14.9**
Argentina	18.1	16.9	15.4	12.2	13.1	14.7	15.0	*	*	*	*
Canada[1]	16.3[2]	13.4	12.3	10.5	13.1	14.5	17.5	19.2	17.7	17.7	17.5
Chile	8.5	15.0	10.5	9.2	12.9	13.3	15.2	17.1	16.3	15.1	16.7
Colombia	12.0	14.6	14.7	14.6	16.6	16.1	17.4	19.5	20.8	*	*
Costa Rica	17.7	22.0	22.7	24.0	25.3	29.6	29.3	39.4	29.1	29.2	34.2
Dominican Republic	*	*	*	26.9[3]	22.2	19.2	24.9	21.1	26.6	29.4	38.4
El Salvador	21.9	20.5	20.2	20.5	20.7	21.9	20.6	26.2	24.0	26.3	*
Guatemala	24.9[4]	21.9	21.3	18.8	18.2	23.2	22.7	26.9	27.9	29.8	27.4
Mexico	6.4[5]	7.4	18.3	20.2	22.4	25.4	24.3	29.8	27.9	27.5	29.4
Nicaragua	*	*	*	21.0	18.6	23.1	23.9	23.8	20.9	25.3	*
Peru	9.2[6]	17.7	18.2	15.5	12.7	15.7	15.8	16.2	13.0†	15.1†	*
Puerto Rico	16.7	13.4	18.6	20.0	22.9	28.0	29.0	30.7	28.2	28.3	28.7
Venezuela	8.3[7]	10.7[8]	10.0	14.8	19.3	21.5	23.4	25.6	27.5	30.8	33.1
EUROPE											
Austria	5.8	3.7	1.7	.8	4.7	—10.7	2.5	5.6	5.6	3.2	3.0
Belgium	7.4	5.1	4.4	2.3	—1.2	.8	4.7	4.5	5.0	4.3	4.1
Bulgaria	18.4	15.8	14.5	10.2	9.0	9.2	11.9	10.6	*	*	*
Czechoslovakia	10.4	8.3	6.7	3.9	6.5	1.7	8.6	12.1	11.9	10.4	11.1
Denmark	11.5	8.7	7.1	7.2	10.2	13.0	13.2	12.4	11.7	10.0	9.4
England and Wales	9.1	4.9	3.4	2.9	2.0	3.0	7 1	8.1	7.0	5.1	4.1
Finland	9.7	8.0	6.3	6.9	2.9	12.4	15.9	15.9	16.2	14.7	13.8
France	2.6	1.3	1.3	— .5	—3.0	.1	7.4	8.1	8.6	7.2	7.8
Germany	9.2	7.1	5.3	7.5	5.2[9]	*	*	*	*	*	*
Berlin	*	*	*	1.2	— .3	—44.5	—16.5	—10.4	—5.0	—3.6	*
Western Germany	*	*	*	*	*	*	3.9	4.9	6.3	6.7	5.8
Greece	5.2[4]	13.0	13.4	12.3	2.3	13.4	18.3	18.1	14.6†	*	*
Hungary	9.2	9.3	7.4	5.9	5.5	— 4.5	3.6	5.9	7.9	7.9†	*
Iceland	12.6	13.8	13.3	10.1	13.2	17.5	17.6	19.0	*	*	*
Ireland	5.9	5.9	5.4	5.1	6.3	8.1	8.9	8.4	9.9	8.7	8.4
Italy	12.8	10.6	10.4	9.3	6.3	4.6	10.7	10.5	11.1	9.6	9.5
Luxembourg	7.4	6.4	5.5	2.8	1.3	— 2.2	2.7	2.3	2.9	1.8	*
Malta and Gozo	12.5	10.6	11.0	13.2	8.7	24.7	25.0	26.0	23.8	23.4	*
Netherlands	15.7	13.4	12.8	11.6	11.6	7.3	21.7	19.7	17.9	15.6	15 2
Northern Ireland	8.2	6.3	6.1	5.6	7.6	8.8	9.8	10.5	10.6	9.8	9.4
Norway	11.7	7.4	5.3	4.8	7.0	10.3	13.2	11.9	11.6	10.5	10.4
Portugal	11.7	13.0	12.4	11.2	8.5	11.5	10.3	10.8	13.5	11.2	11.9
Scotland	10.4	6.7	5.3	4.5	3.3	3.3	7.1	8.7	7.6	6.2	5.4
Spain	9.0	10.5	11.2	4.2	6.6	10.8	8.5	9.3	12.1	10.0	9.1
Sweden	8.0	4.3	2.8	2.8	6.9	9.6	9.2	8.1	8.6	7.4	6.4
Switzerland	7.0	5.6	4.9	3.7	6.4	8.5	8.7	8.0	8.2	7.7	8.0
ASIA											
Ceylon	9.7	15.7	15.4	11.0	17.2	14.7	18.1	25.1	27.4	27.3	27.7
Cyprus	5.8	11.9	14.3	17.4	16.8	21.0	23.9	24.6	23.9	18.9	*
India	5.5	9.6	10.7	11.2	6.5	5.9	10.1	6.9	8.3	10.8	9.4
Israel[10]	21.3[8]	21.5	21.2	19.1	17.4	23.6	22.8	24.5	20.2	22.5	26.4
Japan	12.0	14.3	13.7	11.9	13.7	— 6.0	7.7	19.7	21.5	21.6	17.5
Thailand	*	*	*	18.4	17.9	9.4	9.0	10.3	13.3	16.9	*
AFRICA AND OCEANIA											
Australia	14.6	12.2	8.8	7.7	8.6	11.4	13.5	14.4	13.1	13.4	13.7
Egypt	17.0	17.2	16.1	15.9	12.8	14.9	*	22.2	*	*	* 1
New Zealand	14.0	11.7	9.2	8.4	11.5	13.2	15.5	17.0	16.4	15.8	15.3
Union of South Africa[11]	17.5	16.4	15.0	14.9	16.2	16.1	18.2	18.6	17.6	16.8	16.6

*Not available.
†Provisional.
[1]Excludes Newfoundland, Yukon and Northwest Territories.
[2]Includes estimate for Quebec for 1920.
[3]1936–1939.
[4]1921–1924.
[5]1922–1924.
[6]1923–1924.
[7]1920–1923.
[8]1926–1929.
[9]1940–1943.
[10]Jewish population.
[11]Europeans only.

Source of basic data: various reports by the United Nations, the League of Nations, the International Statistical Institute and the National Office of Vital Statistics; also year books for several countries.

pean continent, among them Western Germany, Italy, and Austria, where overpopulation has been a problem for many years.

The present situation in France and Ireland contrasts sharply with that in the prewar era. The rate of population growth in these two countries since World War II has been the highest in at least three decades. In France, where virtually no population gains had been made for a century and where as recently as 1940-1944 deaths exceeded births by 3.0 per 1,000 population annually, the rate of natural increase has averaged better than 7 per 1,000 each year since 1946. In Ireland, which had been losing population for a century, the upswing has not been as marked. The excess of births over deaths there rose from less than 6 per 1,000 prior to 1940 to somewhat more than 8 per 1,000 in the past six years.

Latin America has a pattern of population growth all its own. During recent years these countries as a group have been the fastest growing in the world. As a result of relatively high birth rates and a reduction of mortality through improved environmental conditions, population increases have averaged more than 20 per 1,000, or better than 2 percent a year. In Puerto Rico, for example, the annual rate of natural increase has been close to 3 percent, or double the rate of growth prior to 1930.

Population statistics are not compiled for many countries in Asia—a continent which includes more than one half of the world's people. What little information is available indicates that Asia has the potentialities for the largest population increase in the future. The countries in this area have the highest birth and death rates in the world, and if improved sanitary and health conditions bring reductions in mortality, the population will rise sharply. In a few of these countries, extraordinary decreases in the death rate have already been achieved through public health programs. In Ceylon, for example, the total mortality has been cut more than one third in the past four years, and the excess of births over deaths has climbed from 18 per 1,000 in 1946 to 28 in 1950. With even less dramatic reductions in the death rate, the populations of China and India could double in 50 to 75 years. It will be recalled that Japan, although not reproducing as close to her physiological maximum as is most of Asia, doubled her population in three quarters of a century. The rate at which people are being added to the already overpopulated areas of the world constitutes one of the major international problems of the day.

Accident Hazards in the Autumn

AUTUMN occupies an intermediate position among the seasons with respect to the toll exacted by fatal accidents. It accounts for a somewhat larger number of deaths from accidental injuries than spring, but for a smaller number than either summer or winter. Yet there are

some major causes of accidental death that take their largest toll in the autumn. One is motor vehicle accidents; the other is firearms. The details appear in the table on the next page, which shows the seasonal distribution of deaths from leading types of accidents in the United States in the three-year period 1946-1948.

About 28 percent of all motor vehicle fatalities in this period occurred in the autumn, that is, from September through November. The proportion is somewhat higher than in summer, even though the volume of travel drops off in the autumn. On a mileage basis, therefore, the margin of difference between the two seasons would be considerably greater. Several factors account for the higher toll of motor vehicle deaths in the autumn than in the summer. The major one is the reduced number of hours of daylight, but also important is the unusual number of holidays during late autumn, the many football week ends, and poor weather. In suburban areas, wet autumn leaves on the ground add appreciably to the hazard of skidding.

Firearm accidents show the largest concentration of fatal injuries in the autumn, when one third of the annual deaths from this cause occur. The rise in firearm fatalities at this season reflects the increase in hunting activities. The circumstances under which many hunters are killed clearly indicate that a large proportion of such deaths are preventable. Some of them result from hunters accidentally shooting themselves or others through careless gun handling; all too often a hunter will climb over or through a fence with his gun carried in a dangerous position. Each year a number of hunters are killed when the guns of their companions are accidentally discharged while being loaded or are caught in the underbrush. Many are fatally wounded when they are mistaken for game.

Burns, conflagrations, and the absorption of poisonous gas, while not reaching their peak mortality until winter, account for a larger proportion of deaths in autumn than in summer. The rise is explained, of course, by the hazards associated with the greater use of heating apparatus at the onset of cooler weather. Many lives would be saved each year if precautions were taken before fires are started to see that chimneys, stoves, and furnaces, inactive during the summer, are still in good working order. This is particularly important for frame buildings or houses with wood-shingle roofs, because extended periods of hot dry weather in the summer have decreased their moisture content and kindling temperature. The hazard of gas poisoning is increased when heating facilities are put into use and windows are closed. Dangerous also is the practice of running automobile motors in garages with the windows and doors shut.

Falls merit special mention, because they rank second only to mo-

SEASONAL VARIATION OF DEATHS FROM SPECIFIED TYPES OF ACCIDENT
UNITED STATES, 1946-1948

CAUSE OF DEATH	AVERAGE ANNUAL NUMBER OF DEATHS	PERCENT BY SEASON				
		TOTAL	SPRING	SUMMER	AUTUMN	WINTER
Accidents (Total)	98,538	100.0	23.8	26.1	24.7	25.4
Motor vehicle	32,789	100.0	22.6	25.0	27.9	24.5
Falls	23,603	100.0	24.8	24.2	24.3	26.7
Conflagration	3,136	100.0	28.6	10.2	18.3	42.9
Burns (except conflagration)	4,711	100.0	26.5	16.0	20.9	36.6
Firearms	2,491	100.0	18.8	21.9	33.8	25.5
Absorption of poisonous gas	1,938	100.0	24.6	9.4	21.7	44.3

Source for basic data: Various reports by the National Office of Vital Statistics.

tor vehicles as a cause of accidental death. The table shows that just under one quarter of the deaths from accidental falls occur in the autumn, practically the same proportion as in the spring and the summer; only the winter months show a somewhat higher toll.

With the approach of autumn, people should be made aware of the special hazards of that season. At the same time they should be reminded that accidents are a serious menace to life at all seasons and that the best assurance of personal safety is the development of a safe way of living that will carry throughout the year.

Factors in the Decrease in Infant Mortality

INFANT mortality in the United States has been cut by about one half in little more than 15 years. In 1933-1934, when nationwide data first became available, the death rate among children under 1 year of age averaged 59 per 1,000 live births; by 1948 the rate had dropped to 32 per 1,000, and now it is somewhat under 30. Virtually all the major causes of infant mortality have shared in the improvement. However, the extent of the gains for the individual causes vary widely; the details appear in the table on page 8.

The infectious diseases have shown the greatest reductions in mortality. The death rate in infancy from the principal communicable diseases of childhood (especially whooping cough), syphilis, and tuberculosis, dropped 75 percent or more between 1933-1934 and 1948, the latest year for which detailed data are available. For diarrhea and enteritis the reduction was nearly 70 percent, and for pneumonia and influenza more than 60 percent. With but few exceptions, these causes of death have their origin in postnatal environmental conditions. The principal factors in the better control of the major infec-

MORTALITY AMONG INFANTS BY CAUSE
UNITED STATES, 1933-1948

CAUSE OF DEATH	DEATH RATES PER 1,000 LIVE BIRTHS						AVERAGE 1933–1934	PERCENT DECLINE 1948 SINCE 1933–1934
	1948	1947	1946	1945	1944	1943		
ALL CAUSES	32.0	32.2	33.8	38.3	39.8	40.4	59.1	46
Principal communicable diseases of childhood*	0.3	0.4	0.4	0.5	0.7	1.0	2.4	88
Syphilis	0.1	0.1	0.2	0.3	0.3	0.3	0.8	88
Tuberculosis	0.1	0.1	0.1	0.2	0.2	0.2	0.4	75
Diarrhea and enteritis	1.8	1.5	1.7	3.0	3.3	3.0	5.8	69
Pneumonia and influenza	3.7	3.6	3.8	5.3	5.6	6.2	9.4	61
Congenital debility and "other diseases peculiar to first year of life"	2.9	3.0	3.1	3.4	3.4	3.4	4.3	33
Premature birth	11.1	11.1	12.1	11.6	11.9	11.8	16.0	31
Injury at birth	3.4	3.5	3.6	3.6	3.6	3.7	4.6	26
Congenital malformations	4.5	4.6	4.5	5.0	5.1	4.9	5.2	13
Accidents	1.0	1.0	0.9	1.0	1.0	1.0	1.0	0
Other and unspecified causes	3.2	3.2	3.4	4.5	4.7	4.9	9.3	66

*Measles, scarlet fever, whooping cough, and diphtheria.

tions in infancy have been the widespread use of chemotherapy and the antibiotics, immunization and other preventive measures, improved infant feeding and care, the increased use of the hospital for confinement and illness, and the marked rise in the standard of living.

But the reductions in infant mortality have not been limited to the causes which originate at or after birth. The death rate from premature birth and from congenital debility and "other diseases peculiar to the first year of life" dropped nearly one third in the period under review. Even the mortality from congenital malformations decreased 14 percent. These reductions have resulted mainly from the better health of mothers during pregnancy and from improved care of babies immediately after birth. It has been clearly demonstrated, for example, that the chances of survival for premature babies are greatly enhanced if they receive special medical and nursing care.

One item in the infant mortality record for the past 15 years is very disappointing: The death rate from accidents has failed to show any decline. The facts on accidents in infancy are not altogether reliable. Deaths ascribed to mechanical suffocation, which constitute almost one half of the accident total under age 1, are often due to undiagnosed respiratory illness. There is, nevertheless, need to strengthen the safety program for babies.*

Altogether, the efforts to conserve infant life have been eminently suc-

* See: STATISTICAL BULLETIN, February 1951, "Fatal Accidents Among Infants," page 6.

cessful, but each year there are still many thousands of children who die needlessly before reaching their first birthday. Premature birth continues to be the major problem, far outranking every other cause of infant mortality. The attention now being focused on this problem by medical and public health agencies encourages the belief that prematurity will be further reduced as a cause of infant death. More adequate prenatal care, proper nutrition for the mother during pregnancy, and improvement in obstetrical practices and training will save many young lives. Much still remains to be done before infant mortality in the Nation as a whole is brought to the low level prevailing in our best communities.

Progress in the Control of Epilepsy

MATERIAL progress has been made in the control of epilepsy in the past 15 years as a result of far-reaching advances in the diagnosis and treatment of the condition and a more enlightened viewpoint among parents and the public generally. Several new drugs have been developed recently which prevent or reduce markedly the frequency of seizures in a large proportion of cases where the cause is not organic. In cases of organic origin, control of epilepsy is often possible through surgery. A substantial decline has been recorded in the mortality from epilepsy, reflecting in part improvement in the management of the condition and of infectious disease among epileptics.

The gains made in the control of epilepsy are of special interest because the disease is still an important health and social problem in the United States. It is estimated that there are now from 500,000 to 800,000 persons in our country suffering from this disorder. Epilepsy is a particularly challenging problem, because it usually has its onset in childhood. About two thirds of the patients have their first attack under age 20. There are about 50,000 epileptics in public institutions; more than one half of those newly admitted each year are children. Moreover, epilepsy, like diabetes, cannot be cured but only kept under control.

Epilepsy is only a minor cause of death. Just under 2,000 deaths were ascribed to it in the United States in 1948, the death rate being 1.3 per 100,000 population. The rates are at a minimum in childhood and rise to a maximum in later life, when cases of organic origin predominate. The mortality among males exceeds that for females, and in each sex it is higher among the colored than among the white. The details appear in the table below.

There is need for a great increase in facilities and personnel to diagnose and treat epilepsy. In the entire country there are only 24 special clinics and only about 150 specialists in this field. A substantial increase in the number of treatment centers, adequately staffed, would not only reduce appreciably the number of

MORTALITY FROM EPILEPSY BY AGE, SEX, AND COLOR
UNITED STATES, 1947-1948

AGE PERIOD (YEARS)	DEATH RATES PER 100,000				RATIO			
	WHITE		COLORED		MALE TO FEMALE RATE		COLORED TO WHITE RATE	
	MALES	FEMALES	MALES	FEMALES	WHITE	COLORED	MALES	FEMALES
ALL AGES.....	1.6	1.1	3.3	1.8	1.5	1.8	2.1	1.6
Under 15.....	0.7	0.6	1.0	0.8	1.2	1.3	1.4	1.3
15-24.....	1.9	1.2	3.5	2.0	1.6	1.8	1.8	1.7
25-44.....	1.9	1.3	5.2	2.5	1.5	2.1	2.7	1.9
45 and over....	1.8	1.2	3.9	2.1	1.5	1.9	2.2	1.8

epileptics who enter institutions but would also make many more of them self-supporting. There is good evidence that four out of every five epileptic children could lead normal and productive lives if proper treatment were available.

Fortunately, both public and private agencies have taken steps to meet the challenge of epilepsy. Programs are under way in which National, State, and local agencies cooperate, and these receive support from the Federal Security Agency. The Maryland State Department of Health, in a pioneering effort, has opened clinics throughout the State and has provided for consultation of the staffs with private physicians. The two medical schools in the State are joined in this program. In Illinois, under the auspices of the University of Illinois College of Medicine, doctors, medical technicians, and public health workers will be trained in current methods of treating the disorder. The International League Against Epilepsy; the American Epilepsy League, with its State affiliates; and The Association for Research in Nervous and Mental Diseases are working to encourage research and to educate the public in the medical and social needs of the epileptic. The United States Public Health Service, under the National Mental Health Act, supports activities in the field. With these developments, the outlook for epileptics is more reassuring.

DEATH RATES* PER 100,000 POLICYHOLDERS FROM SELECTED CAUSES
INDUSTRIAL PREMIUM-PAYING BUSINESS, *Weekly and Monthly Combined*
METROPOLITAN LIFE INSURANCE COMPANY
July 1951

INTERNATIONAL LIST NUMBER (6TH REVISION)	CAUSE OF DEATH	ANNUAL RATE* PER 100,000 POLICYHOLDERS			
		JULY		JAN.-JULY	
		1951	1950	1951	1950
	ALL CAUSES—TOTAL	619.7	596.3	673.2	657.2
1-19	Tuberculosis (all forms)	16.6	19.3	18.2	21.6
1- 8	Tuberculosis of respiratory system	15.1	17.6	16.6	19.7
20-29	Syphilis	2.8	3.8	3.9	4.2
50,55-56,85	Communicable diseases of childhood	.6	.6	.6	.7
80	Acute poliomyelitis	.5	.4	.3	.3
140-205	Malignant neoplasms	124.3	118.8	121.8	119.0
260	Diabetes mellitus	11.6	14.6	15.7	15.3
[330-334,410-450,590-594]	Diseases of the cardiovascular-renal system	305.5	295.3	346.4	340.5
330-334	Vascular lesions, central nervous system	59.2	58.1	66.2	66.3
410-443	Diseases of heart	223.8	215.1	253.9	246.8
410-416	Chronic rheumatic heart disease	11.0	11.5	14.2	14.0
420-422	Arteriosclerotic and degenerative heart disease	160.5	155.1	184.3	176.6
440-443	Hypertension with heart disease	41.7	38.5	44.7	46.4
430-434	Other diseases of heart	10.6	10.0	10.7	9.8
444-447	Hypertension without mention of heart	5.7	5.6	6.6	7.1
450	General arteriosclerosis	5.9	4.8	6.6	6.9
590-594	Nephritis and nephrosis	10.9	11.7	13.1	13.4
490-493	Pneumonia	11.0	10.0	18.5	17.6
480-483	Influenza	.7	.3	3.7	2.5
540-542	Ulcers of stomach and duodenum	3.9	4.1	4.5	4.6
550-553	Appendicitis	1.2	1.5	1.4	1.7
560-561,570	Hernia and intestinal obstruction	4.6	4.8	4.1	4.3
543,571-572	Gastritis, duodenitis, enteritis, etc	2.5	2.6	2.7	2.8
581	Cirrhosis of liver	6.9	7.9	9.0	9.2
640-689	Complications of pregnancy, childbirth	1.3	1.3	1.4	1.7
E963,E970-E979	Suicide	5.8	7.7	6.4	7.0
E964,E980-E984	Homicide	2.2	2.7	2.5	2.8
[E800-E802,E810-E835,E840-E962]	Accidents—total	41.2	37.2	37.1	34.9
E810-E835	Motor vehicle	15.2	14.5	14.2	14.4
	Home	6.2	5.6	7.6	7.6
	Occupational	3.9	3.1	4.2	3.3
E990-E999	War deaths—enemy action	6.5	—	6.6	.1
	All other causes	70.0	63.2	68.5	66.3

*The rates for 1951 are provisional.

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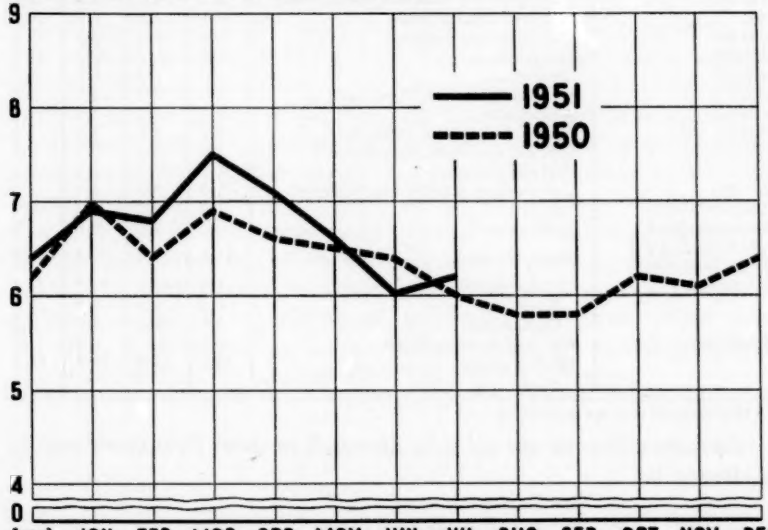
MORTALITY FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE COMPANY • INDUSTRIAL PREMIUM-PAYING BUSINESS
WEEKLY AND MONTHLY COMBINED

DEATH RATES PER 1,000 POLICYHOLDERS • ANNUAL BASIS



(DEC)	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1950	7.0	6.4	6.9	6.6	6.5	6.4	6.0	5.8	5.8	6.2	6.1	6.4
1951	6.9	6.8	7.5	7.1	6.6	6.0	6.2					

1951 figures are provisional

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